Public Health Testimony by Arvind Shaw Jan 31st 2007-
Generations Family Health Center
Weighing in on the Universal Health Care Challenge:

Federally Qualified Health Centers Provide Key Principles for Affordable, Accessible, Quality Health Care

I am in support of the Expansion of the program.
Our Health Center serves the Northeast part of the state, and I feel that the networks delivery performance is worse in the rural areas because of transportation issues, and emphasize that a one stop, FQHC solution is much more effective, than the existing system of no care.

After 11 years of Managed care, the cost avoidance strategies have caused our public health system to start to devolve into the rationing of services.
After 11 years and $5 billion we have a waiting list that is seven months long for kids to be seen for Oral health services. The same is for Mental Health services.
After 11 years and $5 billion there is no Orthopedics, Cardiology, Neurology or sub specialty network.
We have nothing to show for the public health investments that have been made in the name of the patients. These public health funds have all been privatized. We could have paid for Electronic Medical records several times over.

Mis-managed care
In 2005 the Generations claims success rates for Bluecare family plan were 72%.
We hired Robbie, and this year the claims success rates are 84%. She calls them everyday. Every single claim needs to be traced at a cost of $10 a visit.
Please see my letter to Michael Starkowski from DSS.

But the system still needs to be fixed , and may I suggest that the managed care industry needs regulation, and that we take a page out of the way in which the smoke stack industries, another dirty business, has been brought into compliance with Pollution tax credits.

It requires structured oversight in three ways
1) If the MCO's reject claims they should be forwarded to an independent agency for adjudication, and if these claims are paid, a surcharge, of say $50, should be charged for bad claims processing.
2) If the MCO's are unable to provide timely access the patient should be given a voucher, for say $50, so that transportation (out of area) or even the actual service cost for these services (out of network).
3) If the MCO's challenge a claim for medical necessity it should be independently reviewed and adjudicated.
When the MCO's run clean shops they need not worry. Otherwise they should be forced to purchase these prospectively as credits, and this plan performance information should be made public so that consumers are not misled during marketing.

There are five critical elements that the legislature should consider on behalf of the Health centers.
Multi specialty care for Orthopedics, Cardiology and neurology
Case management for chronic disease management
Operational support for the expansion of services, and for retention and recruitment
Electronic Medical records Funding
Full Payment of previous SAGA claims- we are still awaiting payments from July 2005- June 2006.

September 8, 2006

Michael Starkowski
Deputy Commissioner
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033

Dear Mr. Starkowski:

I am writing in response to your letter dated August 30, 2006 regarding proposed changes in the wraparound process. I am glad to hear that the Department is interested in discontinuing the interim wraparound process and transitioning into a more streamlined process for wraparound payments to FQHC's.

As a fundamental basis for the success of this initiative, I hope that DSS, the MCO's and the FQHC's can come up a mutual definition of what constitutes an FQHC visit and a "clean claim". We seek to preserve the intent of the Public Health Service Act's definition of an FQHC visit as a face to face encounter between a clinic or center patient and a physician, physician assistant, nurse practitioner, nurse midwife or visiting nurse (42 CFR Part 405.2463) within a scope of services defined in (42 CFR Part 405.2446) which includes medically necessary preventive and primary health care.

We seek to establish consistencies and common rules among the MCO's. We agree that denials are appropriate if the patient is not eligible or the service is not medically necessary. However, denials for not being the Primary Care Provider (PCP) are not acceptable. For instance, two MCO's require the use of the appropriate PCP for payment and two do not, yet the FQHC service delivered to the patient is exactly the same but payment will only be made by two of the four plans. Recognizing the Medicaid MCO's fashioned their plans from commercial products in traditional private practice settings, we would like the opportunity to educate DSS and the MCO's about the differences in how health care is delivered by an FQHC, given the types of settings in which care is delivered. A few case examples illustrating our frustrations are attached.

As we move forward with the wraparound transition, there are several other issues we would like to see addressed:

- **Consistency of Eligibility Files**: On occasion, the MCO's eligibility files conflict with the EDS eligibility file or the plan's eligibility files are updated retroactively up to two years later, creating a claim denial or a recouped payment well after services are delivered. Often, there is no ability to resubmit the claim to the appropriate party after the denial due to timely filing requirements. In this case, the FQHC verifies eligibility on the date of service in good faith, but eligibility is retroactively changed and the FQHC is left with no payment. We would like to see that the FQHC is not at risk in these scenarios unless payment can be guaranteed. Perhaps an uncompensated care pool can be established to cover these inconsistencies so that the FQHC is not left with the financial risk.

- **FQHC Contact at each MCO**: Currently, two of the four MCO's have made concerted efforts to recognize FQHC's and the role they play delivering care to Medicaid recipients and have designated staff liaisons. To our knowledge, Blue Care Family Plan and Well Care do not have such a structure in place. We ask that all MCO's and subcontractors designate FQHC liaisons and arrange a forum to address FQHC issues.
- **Credentialing**: Generations experiences constant provider turnover, which makes it extremely difficult to credential new providers, locum tenens or community providers from their first date of employment. Credentialing paperwork required by the MCO's is redundant given the fact that Generations, as a condition of JCAHO accreditation has to credential providers exactly the same way. Credentialing takes a significant amount of administrative time conducting duplicative efforts to enroll in each plan. MCO's reject applications if completed on incorrect forms (when there is no notification given of new forms). The use of CAQH credentialing by several of the MCO's inserts yet another time lag in getting providers credentialed. Several MCO's require the provider to sign contracts even though these providers have no legal authority granted by the organization to enter into contracts. We would like to see a streamlined credentialing process including creation of a facility contract, use of an organizational billing number and a common system to become credentialed in all four plans concurrently.
- **Previous Wraparound Due**: The wrap reconciliation for the period July 1, 2004- March 2005 paid 90% of the amount requested and Generations still carries the 10% ($12,681) as a receivable. We would appreciate the remaining payment due for this period.

Resolution of these issues is not insurmountable but does require we all collaborate and negotiate toward a common goal. FQHC's are entitled by federal statute for wraparound payments for FQHC services, not necessarily for what the MCO considers a "clean claim". I would like to assure Generations is not put at additional financial risk. Therefore, I request that a meeting be set with DSS, the FQHC's and appropriate representation from the MCO's before we move forward with the wrap transition. I look forward to hearing from you.

Sincerely,

Arvind Shaw
Executive Director

ATTACHMENT 1: CASE EXAMPLES OF MCO PAYMENT ISSUES

1) Medical MCO (BFCP): Generations has entered into a contractual relationship with Natchaug Hospital (psychiatric hospital) to provide admission physicals and ongoing primary care on-site at their psychiatric transitional care inpatient program for female teens. All teens in this program are enrolled in the Blue Care Family Plan and may be in DCF or parental custody. Often the custodial parent does not even live in the service area. A nurse practitioner visits the floor monthly to conduct admissions physicals and provide preventive or episodic care or treatment of chronic diseases as medically necessary. Under BCFP, services are only paid if provided by the PCP or an exception is on file, which must be filed by the custodial parent or entity. Efforts to attempt to comply with this rule require numerous phone calls to DCF or the parent and often the custodial entity does not follow through to make the PCP change. At this time, 35 claims have been denied with an FQHC value of $4,300 from BCFP for the simple reason we are not designated as the PCP. If these same services were provided to Healthnet members, there would be absolutely no issue with payment. Generations has been trying to remediate this issue with the BCFP provider representative for months without any satisfaction.

2) Dental: Under the State of Connecticut Public Health Statute, dental hygienists may practice independently within their defined scope without the presence of a dentist in public health settings, such as in FQHC dental clinics and on the Generations mobile dental van. However, two of the 3 MCO's will <u>not</u> pay for a periodic exam (done by hygienist) and a comprehensive exam (conducted by dentist) if done within a six-month period. On the dental van which travels to over 30 sites, the hygienist must conduct some level of assessment (periodic exam) before referring to a dentist. The dentist may be a pediatric or general dentist and may be on the van or in our Willimantic clinic. Under the MCO guidelines, the exam provided by the dentist (comprehensive exam) to issue diagnosis and prepare the treatment plan will NOT be paid by the MCO if the child sees the dentist within a six- month period. Thus, Generations is forfeiting payment for the dentist visit from the MCO. In a six-month period, in which time a pediatric dentist came on-staff, Doral has denied 50 dentist visits with a value of $6,300 for this very reason and the other dental plans have similar policies. Access and timeliness to oral health care and the ability to link Medicaid patients with restorative care is already difficult enough without the MCO imposing another barrier. The Dental MCO's clearly set their policies from the perspective of a private dentist setting whereby the hygienist works alongside the dentist all day. They must be educated that oral health care services to Medicaid patients are provided by FQHC's in a great variety of settings including in clinics, on mobile dental vans, in schools and in nursing homes and should accommodate these services into their payment structure.

3). Primary care and preventive services provided through homeless programs on the street, in shelters, on mobile vans: FQHC's deliver medically necessary services in a great variety of settings beyond the traditional clinic setting. In the field, it is unpredictable which patients will be seen since a schedule doesn't apply and there is often no opportunity for electronic communication or phone access to the MCO to verify or change PCP. Because MCO's require the PCP change to be made on or prior to the date of service, often claims are denied because the PCP change was not made and MCO's will not entertain the PCP change after the date of service.